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*AFMS Flight Path: Building Future Leaders*

by

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## Contents

Certificate.....	ii
Contents.....	iii
Illustrations.....	iv
Biography.....	v
Introduction.....	1
AFMS Flight Path.....	2
Promotions.....	6
Redefine Medical Groups (Organization).....	13
Command Opportunities.....	19
Recommendations.....	27
Conclusion.....	35
Bibliography.....	36

## Illustrations

Figure 1, Medical Group.....	13
Figure 2, Operations Group.....	13
Table 1, Officer Promotion.....	10
Table 2, Historical AFMS Squadron Commander Select Rate.....	22
Table 3, Corps Designation Chart.....	21
Table 4, PME Promotion Rate.....	25

## **Biography**

Lt Col Shari F. Silverman is a leader in the Air Force Medical Service. Currently, a student at Air War College, she was previously the Physical Medicine Flight Commander, 436<sup>th</sup> Medical Operations Squadron, Dover Air Force Base, Delaware. As a flight commander, she was responsible for directing all clinical and administrative operations of the Physical Medicine Flight, serving over 19,000 beneficiaries, 77 providers and 12 clinics. In addition, she acted as the Deputy Squadron Commander for approximately 200 active duty and civilian members assigned to the 436<sup>th</sup> Medical Operations Squadron and led the squadron for three-months during the commander's deployment. Concurrently, she led a 57-member Disaster Medical Readiness Team and served as the Biomedical Science Corps Executive advisor to 17 officers. Forging strong relationships with the Kent County Chamber of Commerce, she was the Wing Commander's representative during the 2008 Leadership in Central Delaware program. Lt Col Silverman graduated from the United States Air Force Academy in the top 15 percent of her class. As a medical officer, she has served not only as a medic but in several line-officer positions at the Squadron, Wing, and Headquarters Air Force levels. She is married to Lt Col Shawn Silverman and has a son, Trystan and daughter, Autumn.

## INTRODUCTION

As the nature of warfare has changed since Operations ENDURING FREEDOM and IRAQI FREEDOM, the structure of the Air Force has evolved to adapt to the current expeditionary needs of the Defense Department. The Air Force Medical Service (AFMS) is not spared in this process. The AFMS released the *Flight Path Implementation Guide for the Combat Wing Organization-Medical* in April 2006 as the first step in its transformation to meet the demands of the 21<sup>st</sup> Century.

As a concept, military healthcare is somewhat of an oxymoron. A military organization such as the Air Force intent on “killing people and breaking things” requires a robust healthcare system that meets mission demands yet secures the health of family members. The military healthcare organization with two inseparable missions of military readiness and professional excellence must strive to perform both equally well. The Flight Path strives to create a bridge between the two vastly different missions without comprising either role.

The new Expeditionary AF role coincided with a revolutionary change in preparing airmen through Force Development policies and programs AF-wide. Both events required the AFMS to examine its way of conducting operations. On 28 May 2004, Chief of Staff of the Air Force (CSAF) Gen. John Jumper issued a memo entitled, “Developing Expeditionary Medics—A Flight Path.” This memo tasked the Air Force Surgeon General (AF/SG) to relook the then current Objective Medical Group (OMG) structure. CSAF specifically stated the AFMS required improvements in future senior leader development and medical group organization.<sup>1</sup> The guidance further directed the AF/SG to review the medical group structure for garrisoned and expeditionary medical groups.<sup>2</sup> The AF/SG, Lt Gen. (Dr.) James Roudebush identified, “The overall goal of the “Flight Path” is to develop a streamlined, consistent medical group structure, from clinic to medical center that provides a ready and fit medical force in support of

the Air Expeditionary Force. It assures military and functional medical competence; provides a power projection platform to deploy medics forward; and delivers high quality, cost-effective care.”<sup>3</sup> A secondary goal of reorganization was to minimize the number of layers existing between airmen and commanders.<sup>4</sup>

The purpose of this paper is to examine the Flight Path, in particular, the emphasis on leadership opportunities for AFMS officers. The paper will provide a brief background on Flight Path development and the problems it attempts to address. Although the AFMS is moving in the right direction, cross-functional promotion opportunities, senior leadership positions, Force Development tools, organizational structure at the clinic, and command opportunities continue to need refining to optimize leadership opportunities and meet the intent of the CSAF’s guidance. This paper concludes with a series of recommendations for future Flight Path revisions as well as other areas outside the scope of the Flight Path to build future AFMS warrior-leaders.

## **THE AFMS FLIGHT PATH**

Since 1993, the AFMS has operated under the Objective Medical Group (OMG) structure. At the time, the OMG represented a transformational change in the way medics did business. The OMG created a “product line” focus with four designated squadrons: Medical Operations, Aerospace Medicine, Dental, and Medical Support. The basic structure flexed for groups with less than 300 authorizations and for facilities greater than 600. Under the OMG, the “dual nature” of the medical professional was recognized satisfying both the “line” construct of command and control as well as the accreditation requirements for a healthcare facility.

In 2004, CSAF mandated an OMG “relook” as part of a broader effort to evaluate the development of medical leaders. The relook was dubbed the AFMS Flight Path for short. The Flight Path was designed to “better cultivate the development of expeditionary medics” through the evaluation of three aspects of leadership development 1) Promotions, 2) Redefine Medical

Groups, and 3) Command Opportunities.<sup>5</sup> Nine senior level working groups looked at aspects of each and worked under the following objectives:

- 1) corps-specific force development
- 2) balanced leadership team with the MTF
- 3) compliance with both military and civilian certification/accreditation requirements
- 4) cost-effective mission support in-garrison and deployed
- 5) provide streamlined/consistent OMG structure from clinic to medical center
- 6) focus on functional/clinical expertise
- 7) command opportunity in line with the Line of the Air Force (LAF)
- 8) reduced overhead costs/decreased administrative burden
- 9) trains/sustains expeditionary medics.<sup>6,7</sup>

These panels made a number of recommendations that were quickly acted upon. Per Assistant Surgeon General for Medical Force Development, “The overarching goal of the "Flight Path" is to guide more deliberate development for AFMS officers and senior enlisted, placing the member in the right job at the right time and setting them up for career success and personal satisfaction while maintaining expertise at the frontlines of patient care.”<sup>8</sup> Leadership, both in garrison and in the expeditionary environment, therefore, is the real focus of the Flight Path.

Under the Promotion initiative, the CSAF letter provided for designated General Officer opportunities for all corps.<sup>9</sup> Both the Biomedical Science Corps (BSC) and Medical Service Corps (MSC) gained a Brigadier General slot. These billets were mandated in an effort to eliminate corps competition for senior leadership positions.<sup>10</sup> Prior to Flight Path guidance, neither corps were guaranteed senior leadership opportunities beyond Colonel.

Organizationally, medical treatment facilities (MTF) were redefined into several distinct categories: medical wing, medical centers, hospitals, clinic plus, clinics, and training groups.<sup>11,12</sup> At each MTF, mission and size may affect the basic clinic structure and variations may be authorized to comply with unique situations. Initially the Flight Path favored a corporate model for small MTFs and recommended a “Group without Squadron” structure for MTFs with less

than 250 manpower authorizations.<sup>13</sup> Under the corporate model 34 MTFs were targeted for squadron deactivation. In April 2007, NOVA reversed the decision.<sup>14</sup> According to Lt Gen Roudebush, “The SGs unanimously supported maintaining our squadron organization. This confirmed what we had been hearing from Line leadership across the Air Force. Medical groups with squadrons best maintain our alignment under the Wing Commander.”<sup>15</sup> The hybrid model of AF and corporate healthcare structure under the OMG was retained, and the small numbers of deactivated squadrons were reactivated. In general, the Flight Path maintains the four squadron framework of OMG with an additional two squadrons for hospitals/medical centers as defined in AFI 38-101, *Air Force Organization*.<sup>16</sup> Exceptions to structure exist especially under the Medical Wing (MDW) model.

Finally, command opportunities at the squadron and group levels aligned with the “line” construct and took into consideration the cross-functional differences among the corps. Squadron and Group Command opportunities were limited to single tours at two and three year tour lengths respectively with few exceptions. Under the OMG model, individuals were allowed multiple command opportunities under a tiered approach. MTFs were divided into small, medium, and large MTFs. Command development mirrored the tiered approach as leaders moved from command at small to large MTFs. Once individuals entered the command track under this configuration, they could remain in the command track for their entire career. This career command track is virtually impossible under the new Flight Path. Furthermore, the Flight Path eliminates the “corps-neutral” environment emphasized under the OMG. “Corps neutral” opportunities under OMG tended to favor physicians and hospital administrators for command.

As the AF/SG emphasized, command opportunities under the Flight Path should foster “corps-specific force development, requirements-driven leadership opportunities, and balanced

leadership teams within the MTF.”<sup>17</sup> To meet this goal, the Flight Path designated corps-specific command at all levels. The starting assumption was that hospital and medical center command opportunities would be limited to physicians (MC) and training groups to nurses (NC) as these commands are normally stepping stones to General Officer and other key AFMS Colonel positions.<sup>18,19</sup> Furthermore, the Defense Officer Personnel Management Act (DOPMA) Colonels Grade Review attempted to balance the 51 DOPMA group commander positions between the three DOPMA Corps (NC, MSC, and BSC).<sup>20</sup> The Corps Designation Chart matches corps with size and mission of the organization to fill command positions. By design, a Medical Group (MDG) would have a commander representative from each corps fulfilling the goal for a balanced leadership team within each MTF. The same would apply to MDW.

A separate inherent focus of the Flight Path is to restore the prestige of the functional advisor position. The functional expertise of an MTF resides in the three-letter positions: SGH (Chief of Medical Staff), SGN (Chief Nurse), SGA (Administrator), SGP (Chief of Aerospace Medicine), SGD (Chief of Dental Services), SGB (BSC Executive), as well as the group superintendent.<sup>21</sup> The functional advisor performs roles similar to that envisioned in the corporate model of healthcare and mirrors the executive layout expected by civilian accreditation institutions. Functional advisors provide the professional and technical expertise to medical commanders on issues regarding optimal healthcare delivery and organizational management.<sup>22</sup> They also serve as senior mentors and advise commanders on corps-pertinent career development<sup>23</sup> and provide the tie to the civilian corporate healthcare model.<sup>24</sup> Squadron commanders may or may not “dual-hat” as functional advisors. Time will only tell if the prestige attributed to the three-letter position has been achieved under the current Flight Path.

Since its inception, the Flight Path has undergone 33 revisions. The most recent version was published 14 February 2008 and is the version addressed in this paper. To limit the scope of research, the focus will be on officer development and not enlisted development clearly outlined in the Flight Path. The Flight Path, as a whole, has reconciled some of the problems associated with the OMG but continues to require refinement in each of the three areas (Promotions, Redefine Medical Groups, and Command Opportunities) identified in the CSAF memo.

## **PROMOTIONS**

Although the Flight Path created General Officer billets for the BSC and MSC, O-4 to O-6 promotion opportunities have not changed. BSCs continue to suffer poor field grade promotion rates. The NC is making some headway and promotion timelines are beginning to synch with line counterparts. MSCs, on the other hand, fare much better with accelerated promotion rates and timelines. However, key senior leadership positions are primarily limited to MC. Physicians dominated “corps-neutral” General Officer positions under the OMG, and designating premier command opportunities for MC under the Flight Path virtually ensures the continuation of the trend. Instead, promotions designed to open up more senior leadership positions for historically under-represented corps, primarily BSCs, and minimize inter-corps rivalry have actually done the opposite.

Part of the promotion disparity among the corps stems from the management of personnel operating under two distinctly different promotion systems. On one side, BSC, NC, and MSCs are constrained under DOPMA which according to AFI 38-201, sets “Air Force Grade Ceilings” in the field grade ranks.<sup>25</sup> Conversely, MC and DC positions are excluded from promotion ceilings.<sup>26</sup> As a result, MC and DC tend to be “rank heavy” at a rate of 7-23% higher than other medics in the field grade officer positions.<sup>27</sup>

At the heart of DOPMA is the *up-or-out promotion system*. In the judgment of Congress, the common promotion, separation, and retirement rules provide “in peacetime, a youthful, vigorous, full combat-ready officer corps.”<sup>28</sup> The inequity in DOPMA occurs in the management of career fields. The AFMS is not immune to the problems of DOPMA. BSC and NC promotion rates have steadily declined and inversely, timing between promotion boards has increased. Conversely, MSCs have fared much better where promotion rates mirror their line peers for O-4 and O-5. At the O-6 level, MSC promotion rates actually exceed line and medic DOPMA counterparts for two reasons. For one, a large majority of MSCs are prior-enlisted and retire prior to reaching O-6 at approximately the 24-26 year point. Secondly, high rate of civilian employment opportunities contribute to the MSC natural exodus. According to a 1993 RAND study, “The ideal officer career profile is achieved *only* when DOPMA effectively balances the grade tables, promotion opportunity and timing, and tenure rules, and when officers voluntarily show the “normal” officer attrition, e.g., *continuation rates* that were assumed by DOPMA planners.”<sup>29</sup> There is no “one answer” to DOPMA. Each corps has unique characteristics that must be addressed to solve the promotion differences within AFMS.

Since 1967, physicians and dentists have not counted in the grade table.<sup>30</sup> In 1980, DOPMA codified the promotion system recognizing “that officers working in a small number of particular specialties are “out of the normal promotion stream” and receive their grade based upon professional education, experience, and service rather than service in the military.”<sup>31</sup> Furthermore, the RAND study indicates “it has long been held that because such officers have professional rather than “line” military experience, ‘it is impossible for them to compete for promotion on an equal footing with other officers having more general experience.’”<sup>32</sup> DOPMA also delegated promotion system flexibility to each service secretary who “can establish separate

‘competitive categories for promotion...for officers performing functions requiring special training or experience.’”<sup>33</sup> As such, medics do not compete against non-medics (line officers) for promotion. In reality, physicians only compete against physicians; dentists compete against dentists; nurses against nurses, etc.... Within AFMS, the only officers who compete against officers with different career fields are those in the BSC. Consequently, the original concerns for establishing a separate promotion system from DOPMA for specialists competing against line counterparts is all for naught.

The other non-stated objective of a separate promotion system for MC and DC is it gives them an additional incentive to stay in the service. Additionally, Title 37 USC, *Pay and Allowance of the Uniformed Services*, provides for specialty and bonus pay as retention incentives for professional expertise. However, promotions should not substitute for lack of military experience. Rank should be earned and not awarded based on professional degrees alone. Holding professionals to promotion standards only holds them accountable to their peers.

The gap between DOPMA and non-DOPMA promotion rates persists, and the Flight Path does little to address it. Furthermore, it does nothing to address the long-term issue of BSC and NC promotions. This issue was completely ignored in the initial guidance to senior leader panels and should be examined as part of the CSAF guidance to perform a comprehensive review to include “promotions.” Although not a specific Flight Path goal, promotion opportunities indirectly affect the ability for “rank deficient” corps to compete for senior leadership positions. In the AFMS, DOPMA has limited promotion opportunities for BSC and NC.

The type of senior leadership positions assigned via corps also does not help alleviate gaps between medic corps. All 14 Group Command and 4 Wing Command positions available at the hospital/medical center levels are reserved for MC and DC. Two of the three deployed

Group Command positions are designated MC. Of the 11 corps neutral General Officer positions, MC fill all but two. Vast differences in rank and promotion rates further bias the AFMS to a non-DOPMA corps led entity. The Flight Path has done little to rectify these promotion gaps even those that exist among the DOPMA constrained corps.

As the RAND study indicates, “Managing the various competitive categories has increasingly become a problem under DOPMA, as it was for some competitive categories prior to DOPMA.”<sup>34</sup> Arguably the most diverse AFMS corps, BSC has 17 clinical and non-clinical specialties competing for promotion, similar to the line promotion board. All other AFMS corps (MSC, NC, MC, and DC) are fairly homogenous. Historically poor retention rates of specialized professionals drives the nearly 100% (O-4 and O-5) promotion rate of non-DOPMA officers. In the 10 years prior to 2001, the promotion rate for MC averaged 74% to O-5.<sup>35</sup> Now O-4 and O-5 MC and DC promotion rates tend to be over-inflated. BSC and NC experience the opposite effect where O-5 promotion rates are 20% less than line and other corps (Table 1). Additionally, timelines between BSC promotion boards have been extended to cap promotion rates under DOPMA; therefore, officers must wait, on average, two years longer than line equivalents to meet an O-5 board. Until the most recent promotion board, NC experienced similar promotion discrepancies. MSC O-5 promotion rates are actually slightly ahead of the line. Not until O-6 do MC and DC “compete” for promotions, and promotion rates begin to mirror DOPMA targets.

To line counterparts, rank reflects a balance of professional and military acumen. While professional expertise should be a given, military expertise is gained through a wide variety of experiences to include assignments, deployments, and leadership positions. As the first priority of the medical service is support of AF combat units,<sup>36</sup> a clear understanding of the AF mission and the value of medical support services is an important component of military medicine.

Table 1: Officer Promotion<sup>37</sup>

Year	Officer Pay Grade	Promotion Opportunity	BSC	MSC	NC	MC*	DC*	Line
	O-2	100% (if fully qualified)						
	O-3	95%						
2008	O-4	80%	87.60%		75.40%			
2007			88.00%	92.30%	79.70%	99.70%	100%	94.20%
2006			88.30%	91.50%	75.00%	99.30%	98%	93.30%
2005			86.70%	91.00%		98.90%	97%	92.40%
2008	O-5	70%	52.90%		60%			
2007B				74.10%				
2007			52.40%	76.20%	52%	96.90%	100%	74.70%
2006B								74.80%
2006			52.10%	69.20%	NB	99.30%	96%	74.50%
2005			53.80%	72.50%	49%	98.50%	100%	73.80%
2008	O-6	50%	47.20%					45.30%
2007			47.10%	58.10%	46.90%	49.40%	56.30%	45.40%
2006			48.10%	52.20%	38.90%	54.00%	71.40%	45.30%
2005			NB	56.50%	35.70%	62.30%	84.00%	45.00%

\* non-DOPMA

NB = No board

AFMS leadership should reflect that understanding. According to the Flight Path, “Throughout an individual’s career, rewards should be clear for functional/clinical, academic/educational, and leadership competence.”<sup>38</sup> Promotions are the most visual incentive and thus should be reserved for the “cream of the crop” in each career field. Non-DOPMA corps officers are viewed through the same lens and should reflect the “best and brightest” at all levels of rank and not just at O-6.

All corps members should be “medics.” Instead, the Flight Path reinforces paradigms and fosters a physician-centric culture. Promotions at the General Officer rank reflect this culture. The AF has undergone a paradigm shift within the last 60 years as senior leadership has transitioned from bomber pilots to fighter pilots and now finds itself under a Special Operations

aviator as CSAF. The AFMS requires a similar shift. Part of the paradigm shift begins with educating and demonstrating to senior line leaders the value of medic leadership independent of corps. Education efforts should extend to the MAJCOM SG and COCOM SG positions that are physician-filled. Just as the Wing Commander's position relies on leadership, so should the MDG and MDW Commander positions. Leave the real functional clinical expertise to the three-letters. Instead of relying on Group Commanders as the physician of choice, the AFMS should restore the prestige of the SGP and SGH to fulfill that role. Cultural shifts take years to evolve yet the Flight Path guarantees only MC to fill "corps-neutral" General Officer by limiting command opportunities at hospitals and medical centers.

Of the 14 AFMS General Officer positions, Title 10 USC only establishes permanent General Officer positions for 1) the Surgeon General (MC Lt Gen), 2) Assistant Surgeon General, Chief of Dental Corps (Maj Gen), and Assistant Surgeon General, Chief of Nursing Corps (Maj Gen).<sup>39</sup> These are CSAF-appointed positions and reside outside normal promotion processes. Although MSC and BSC "gained" 1-star positions, they are not dictated by law. This is certainly an improvement under OMG which basically overlooked all but MC for any General Officer position outside Title 10 provisions. In actuality, excluding Title 10 USC provisions, all 11 General Officer positions are corps neutral yet they have not been viewed as such. Opportunities existed and still exist for additional MSC, NC, BSC, and DC General Officers yet the Flight Path saves the premier senior leadership positions for MC.

As the Flight Path is specifically geared toward developing officers to fill the three Title 10 USC positions, it ignores the need to develop leaders. According to AFDD 2.4-2, *Health Services*, key leadership positions such as the AF Forces (AFFOR) Surgeon and the Deployed Medical Commander are corps-neutral officers filled from active, guard, and reserve forces.<sup>40</sup>

Senior leadership positions should instead focus on building quality leaders regardless of corps to align with the AFMS readiness mission and doctrine. Instead, command opportunities at the hospital and medical center, necessary to achieve the requisite credentials to attain General Officer rank and to fill key Colonel positions, have been completely eliminated for DOPMA constrained medics. Without the two General Officer positions assigned through the Flight Path, it would be even more difficult for non-physicians to achieve rank beyond O-6. The Flight Path took a big step in the right direction to create General Officer billets for MSC and BSC, yet it has not gone far enough to address the existing promotion inequity among all medic corps.

### **REDEFINE MEDICAL GROUPS (ORGANIZATION)**

The organizational structure under the 2008 Flight Path did not vary from the OMG where the AFMS adopted a hybrid corporate and military model. The only change occurred in the designation of corps-specific senior leadership positions for command. The retention of a hybrid organizational model and designating corps to groups and squadrons has created three problems: 1) unnecessary retention of small squadrons, 2) increased administrative burden on dual-hatted squadron commanders, and 3) increased the complexity and layering between airmen and commanders.

To examine the efficacy of the Flight Path's impact, it is necessary to look at published AF guidance and the organizational operation of AF units. According to AFI 38-101, *Air Force Organization*, organizations must be structured to accomplish wartime tasks in both peacetime and wartime and are grouped according to function.<sup>41</sup> Furthermore, AFD 38-1, *Manpower and Organization*, clarifies that AF organization "requires simple, streamlined structures designed for seamless transition from peace to war."<sup>42</sup> The Flight Path complies with AF guidance and can easily transition to a wartime footing. Additional characteristics desired of an AF organization

as cited in AFPD 38-1 are 1) mission orientation, 2) unambiguous command, 3) decentralization, 4) agility, 5) flexibility, 6) simplicity, and 7) standardization.<sup>43</sup> Current Flight Path guidelines provide a good foundation for mission orientation, decentralization, agility, flexibility, and standardization across organizations. Yet, the Flight Path violates principles of simplicity and unambiguous command.

First, the Flight Path continues to provide flexible, agile, and standardized organization oriented to peacetime and expeditionary medicine under a decentralized command and control system. As such, the Flight Path provides medical support in the form of an integrated delivery system of health to cover mental, physical, and dental needs.<sup>44</sup> It also covers the full spectrum of AF organizational building blocks from squadrons to wings during peacetime care. As AFI 38-101 defines the squadron as the “basic unit in the Air Force” and is the “building block” providing “specific operational or support capability.”<sup>45</sup> The OMG structure prevailed over any changes attempted under earlier Flight Path versions. In most cases, Flight Path organizational structure mirrors the OMG where squadrons are defined along “product lines” (Figure 1).

Figure 1, Medical Group

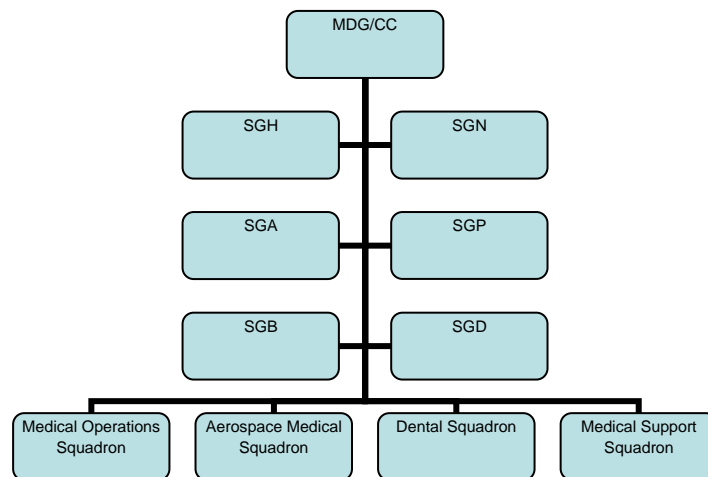
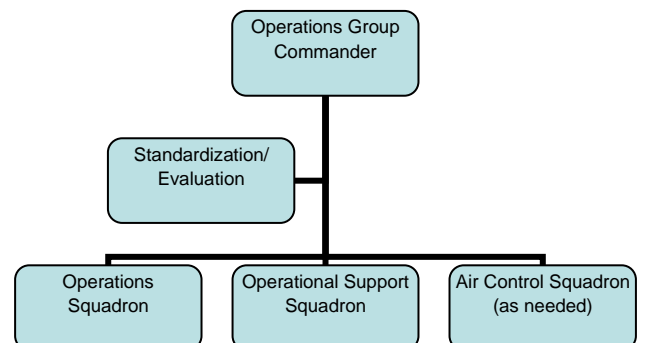


Figure 2, Operations Group



In the cases of MTFs with less than 200-300 manpower authorizations, variations can and do

exist i.e. the Dental Squadron (DS) and Aeromedical Squadron (AMDS) can combine into an Aeromedical Dental Squadron (ADOS) or can reside as flights under the Medical Operations Squadron (MDOS). Conversely, at large facilities > 600, MDOS splits into three or more entities i.e. an MDOS, Surgical Operations Squadron, and Inpatient Operations Squadron. The Medical Support Squadron (MDSS) typically remains static regardless of MTF size. Overall, the MDG resembles the Operations Group defined in AFI 38-101 and as depicted in Figure 2.

With regards to simplicity, the Flight Path has retained numerous small squadrons that could be consolidated without restricting the functioning MDG core. In an effort to maintain Force Development needs across five separate medic corps, the Flight Path maintained squadrons where squadrons need not exist. In the case of some MDGs (clinics), where three squadrons existed, now there are four. For example, the 436<sup>th</sup> MDG at Dover with around 300 members went from three squadrons (MDOS, AMDS, and MDSS) to four squadrons (MDOS, AMDS, MDSS, and DS). The total number of AFMS squadrons did not vary from the OMG. However, the net result is a multitude of small squadrons coinciding with an MDOS up to three times larger within a single MTF. Again, “product line” divisions under the clinic model dictate this discrepancy. Restructuring clinics along mission or functional lines such as a “clinical squadron” and a “non-clinical” squadron could eliminate one or two squadrons. However, creating an ADOS instead of an AMDS with a separate DS would simplify organizational structure but may not align in-garrison and deployed missions.

In the deployed environment, the Expeditionary Medical Support unit (EMEDS) uses an incremental, modular approach to build a medical capability according to mission needs across the full spectrum of operations.<sup>46</sup> Teams are deployed either along functional lines or as specialized teams under Unit Type Codes. In this respect, the Flight Path mirrors much of the

functional expertise needed to transition from peacetime to wartime and meets the CSAF intent to consider garrisoned and expeditionary medical groups.<sup>47</sup>

Instead of creating a more simplified organization, the recent reorganization has actually accomplished the reverse as some squadron commanders are now tasked with managing the additional role of functional advisor. Combined with the elimination of secretarial positions and admin-supported staff at the AF level, more and more administrative duties are being pushed up to the squadron commander. “Cost-saving authorizations” are partly to blame for the hybrid positions although reinstating squadrons largely drove this measure.<sup>48</sup> Under the OMG, many squadron commanders were dual-hatted by virtue of career field and seniority within the facility; however, the Flight Path now formally designates dual-hatting for any future commander. This has removed the flexibility of the Group and Squadron Commander to designate an alternate senior corps member to perform the functional advisor role.

The mandatory “dual-hatting” of squadron commanders also convolutes the normal chain-of-command. This situation creates an ambiguous and unnecessary reporting dilemma for some medics, both officer and enlisted. Dual-hatted commanders now provide career advice and review performance reports to officers assigned to a different squadron. At least under the OMG, commanders retained the option to dual-hat other individuals, such as Flight Commanders, without command authority.

In an effort to save manpower, the Flight Path did not achieve its objective to flat-line layers between the airmen and commander. Instead, the layering effect has transformed into a matrix. According to AFD 38-1, “Organizational structure should be as plain and straightforward as possible because complexity often inhibits rather than facilitates organizational effectiveness.”<sup>49</sup> Dual-hatting squadron commanders as functional advisors

inherently create confusion and place an unnecessary demand on a commander's time and resources which is rapidly becoming scarce in today's manpower-constrained AF.

Under the Flight Path's four squadron construct, force development for each corps is fairly straightforward. MSC normally commands MDSS (some provisions allow BSC to command MDSS with an MSC Group Commander), DC commands DS, MC or BSC commands AMDS, and NC, MC, or BSC commands MDOS. Functional advisor duties may or may not be combined with squadron command while group commanders will never serve as functional advisors.<sup>50</sup> During Flight Path development, Corps Chiefs determined these dual positions depending on mission size and complexity.<sup>51</sup> In some cases, the functional advisor-squadron command merger makes sense when command overlaps seamlessly with the duties of functional advisor. For example, the DS Commander is responsible for only Dental Corps members. In this instance, the DS Commander is best suited to perform a "dual role" and prevents excessive administrative overhead. For all other squadrons, the duality is not so "clean-cut."

Where the "dual-hat" role becomes more cumbersome is under AMDS and MDOS and to a lesser extent MDSS. AMDS and MDOS are typically composed of at least three corps (MC, NC, and BSC). Under MDSS, there are typically only MSC and BSC personnel. The "command layering" effect plays a prominent factor in these situations. Again, using the 436<sup>th</sup> MDG at Dover as an example, the MDOS Commander also serves as SGN. The dual functioning MDOS commander-SGN makes all nursing personnel decisions within the medical group including decisions regarding nurses assigned to other squadrons i.e. AMDS. Besides having the largest squadron within the medical group, the MDOS Commander must also "balance" a full-time administrative job as SGN. With all of the duties associated with the SGN position, it is easy to understand why it is a separate position at all medical facilities but Dover

AFB. At the other end of the spectrum, the AMDS-assigned nurse has to coordinate with two squadron commanders vice one, clearly an ambiguous structure. In this scenario, the functional advisor role has become equally if not more important than that of the squadron commander. The art of leadership under the squadron commander has been relegated to the functional advisor, and the directive to “minimize layers” between the airman and the commander has become lost.

Overall the reorganization maintained a well-functioning structure under OMG but retained the complexities and ambiguous operating environment inherent in a dual corporate-military model. Command-leveling initiatives in conjunction with force development concerns maintain an inordinate amount of squadrons in addition to creating dual administrative roles for squadron commanders and functional advisors. “Dual-hatting” functional expertise with squadron command positions, in some instances, has created reporting dilemmas between airmen and their commanders. Furthermore, these additional duties burden squadron commanders with tasks not found in any other AF organization, potentially threatening command and control of the squadron. The cross-corps “leadership balance” created under the Flight Path tilts in favor of the “dual-hatted” squadron commander/functional advisor who has administrative “control” of corps members across the Medical Group. In summary, three problems exist with the current Flight Path structure: 1) designating corps-specific squadrons has unnecessarily retained squadrons, 2) “dual-hatting” unnecessarily burdens squadron commander with additional duties, and 3) the plan has increased rather than decreased the “layering” effect between airmen and commanders.

### **COMMAND OPPORTUNITIES**

Although the Flight Path appears to have solved Force Development issues associated with command, it created an unintended effect of reducing rather than increasing senior leadership opportunities. All command opportunities from the operational to strategic levels are

now linked to corps. The Flight Path superficially met its goal “to link command opportunity to senior level requirements” at the cost of limiting MAJCOM’s and Wing Commander’s ability to choose commanders.<sup>52</sup> Now instead of the expressed concern that the emphasis on command as the path to promotion and senior leadership positions has eroded functional skill sets in senior medics, the Flight Path is now eroding the leadership emphasis of command to functional skills sets. The core of the problem is two-fold: 1) coalescence of functional advisor and squadron commander positions and 2) limiting wing and group command positions by corps. The latter problem, in effect, reduces corps-neutral senior leadership opportunities.

To solve the problems associated with command opportunities, a distinct separation should exist between most functional advisor positions and command. Where functional advisor positions value professional expertise, command opportunities should value military expertise. Both should emphasize varying degrees of leadership. Functional advisors support commanders by providing professional and specialized technical perspectives.<sup>53</sup> However, “developing credible and competent squadron commanders is the result of many factors from selecting the right people through training, education, experience, mentoring, performance measurement, and even the promotion system.”<sup>54</sup> As such, each corps Development Teams (DT) should be looking for two different skill sets at command screening boards (CSB) and for boarded three-letter positions. Where functional advisors should weigh heavily toward corps-specific skills, command screening should be focused on leadership skills. Corps DTs essentially should look for “line” leadership traits in commanders as these positions are directly linked to a military construct. The mantra that “leadership does not equal command, but all commanders should be leaders”<sup>55</sup> should prevail during CSBs.

Linking corps traits to command billets at the squadron level under the current guidance

does appear to provide a balanced leadership team at the functional/tactical level of squadron command. The same argument does not hold at wing and group command. In the expeditionary environment, the DMC (Deployed Medical Commander) commands the deployed medical facility (e.g. Expeditionary Medical Group) and functions similarly to a MDG commander.<sup>56</sup> The DMC is assigned regardless of Air Force Specialty Code (AFSC) and must currently be a “sitting” commander. At the wing and group level, commanders should “understand the broader Air Force perspectives and the integration of diverse people [i.e. corps] and their capabilities to execute operations.”<sup>57</sup> Emphasis at the MTF level in garrison and in the deployed environment should be on leadership capability versus corps-specific knowledge. A well-rounded leader with a broad array of knowledge across the healthcare arena and a solid understanding of the AF mission should prevail over corps-specific skills.

According to AFDD 1-1, *Leadership and Force Development*, the primary role of a military leader is “to motivate and direct people to carry out the unit’s mission successfully.”<sup>58</sup> Tactical level leaders focus on developing personal leadership traits at the face-to-face level and on honing technical skills. Corps-specific competencies continue to be an area of emphasis at this level. The Squadron Commander is the epitome of the tactical level leader. At this level, leaders should be a master in their field and begin to expand leadership opportunities outside their career field. This does not mean that officers have to leave the AFMS but should broaden their horizons within the AFMS. As leaders move into the operational and strategic areas of leadership, leadership decisions shift from technical problem-solving to solving more complex, ill-defined problems with a higher potential for organizational impact.

The AF defines three enduring leadership competencies: personal leadership, leading people/teams, and leading the institution common to military leaders.<sup>59</sup> As leaders move from

the tactical to strategic level, emphasis shifts from personal leadership traits to institutional leadership.<sup>60</sup> “By deliberately exposing people to a broader range of experiences, by ensuring each Airman’s developmental experience is both valuable and meaningful, and by cultivating the enduring leadership competencies, the Air Force creates leaders that are more flexible and adaptable in a force that has an even greater sense of belonging and performance.”<sup>61</sup> Designating command reduces doctrinal intent to expose leaders to a broad array of opportunities within the MTF to gain experience and familiarity of operations outside the normal career-oriented path and thereby, limits the ability of the AFMS to develop operational and strategic level leaders.

Historically, CSBs chose a disproportionate number of MSCs and MCs for command opportunities compared to other corps (Table 2).

Table 2: Historical AFMS Squadron Commander Select Rate<sup>62</sup>

	CY2001		CY2002		CY2003		CY2004		CY2005	
Corps	Matched	Rate	Matched	Rate	Matched	Rate	Matched	Rate	Matched	Rate
BSC	14	31%	13	34.20%	12	38.70%	10	27%	9	36%
DC	2	40%	1	33%	3	60%	1	100%	4	80%
MC	21	75%	14	82.40%	18	64.30%	14	93.30%	17	73.90%
MSC	31	72.10%	23	95.80%	32	91.40%	32	78%	26	57.80%
NC	10	48.70%	18	41.90%	13	39.40%	18	50%	13	40.60%
Total	87	54.40%	69	55.20%	78	59.10%	75	57.70%	69	53.10%
	CY2006		CY2007		CY2008		CY2009			
Corps	Matched	Rate	Matched	Rate	Matched	Rate	Matched	Rate		
BSC	14	43.80%	9	37.50%	17	48.60%	17	48.60%		
DC	0	0%	2	33.30%	2	50%	2	50%		
MC	12	75%	8	53.30%	19	76%	19	76%		
MSC	29	85.30%	17	58.60%	29	85.30%	29	85.30%		
NC	19	57.60%	4	25%	18	56.30%	18	56.30%		
Total	74	61.70%	40	44.40%	85	65.40%	85	65.40%		

The Flight Path transformation theoretically gave the NC and BSC an approximate 10% increase in command selection rates. Yet, in comparison, the overall selection rate of the other corps remained fairly static. Match rates for MSC and MC are still 20-30% higher than other corps.

Medical force structure and command designation have simply not created a completely balanced senior leadership playing field. MSC commanders continue to outpace the other corps members at a squadron command match rate of two to one. In this respect, the military healthcare model mirrors that of a civilian hospital network where administrators (MSCs) are the hospital “CEOs.” As the Administrator (SGA), MSCs run the business aspects of a MTF. In peacetime, readiness frequently loses out to meeting local business plans and “relative value units” of patient care. Not meeting the business plan runs the risk of losing manpower and budgetary cuts. The AFMS is averse to transferring a bulk of its care to downtown providers as the medical service runs the risk of losing organic skill sets necessary to treat battlefield casualties. Hence, the AFMS walks a fine line between meeting its business plan and accomplishing its readiness mission. MSCs truly possess the most “relevant” knowledge to run a hospital organization under the civilian model of care for accreditation standards but not necessarily a MTF with force readiness concerns and command authority. The “administrator bias” becomes apparent in the Corps Designation Chart (Table 3) where MSCs have been designated to control squadron and group command at twice the rate that should be expected based solely on the percentage of the AFMS officer corps.

Table 3: Corps Designation Chart<sup>63</sup>

Corps	State of the Force*	Lt Col Squadron Breakout	Colonel Squadron Breakout	Combined Squadron Breakout	Dep/Vice Breakout	Group Command Breakout	Wing Command
MC	3,395 (31%)	41 (22%)	38 (36%)	79 (27%)	4 (22%)	22 (27%)	1 (50%)
DC	855 (8%)	7 (4%)	33 (31%)	40 (14%)	2 (11%)	8 (10%)	1 (50%)
MSC	1,045 (10%)	63 (34%)	0 (0%)	63 (22%)	4 (22%)	18 (22%)	
NC	3,259 (30%)	35 (19%)	22 (21%)	57 (20%)	4 (22%)	19 (23%)	
BSC	2,228 (21%)	40 (22%)	13 (12%)	53 (18%)	4 (22%)	16 (19%)	
Total	10,782 (100%)	185 (100%)	106 (100%)	291 (100%)	18 (100%)	83 (100%)	2 (100%)

Note: data represented by Total/Percentage Staffing by Corps

\*As of Jul 08

As physicians, the MC are also highly valued within the organization especially in senior leadership positions. Physicians hold 10 of the 14 AFMS General Officer positions. They are the quintessential “pilots” of the MTF whereas all other medics are the support staff. As such, key senior leadership positions are designated for physicians. Nowhere is this more evident than the group command breakout. MSCs aside, the Corps Designation Chart appears to represent a fairly even distribution of corps to command positions (Table 3). When delving more into the types of command, quite a different picture emerges. The Flight Path has eliminated command opportunities for DOPMA corps at the 18 hospitals and medical centers. These positions are the natural stepping stones to General Officer and are largely designated for MC. Medical degrees do not necessarily equate to quality military leaders although the Flight Path seems to support the idea. Line leadership biases also continue the trend of physician dominated senior leader positions within the AFMS.

Under the current guidance, medic command opportunities clearly focus on “best in breed” (corps-specific) versus “best in show” (corps-neutral). AF Specialty Code (AFSC) plays a huge factor in senior leadership assignments, promotions, and command opportunities. Corps opportunities, although “equal” prior to the Flight Path, still favored MC and MSC for command positions as seen in Table 2. Culturally, the AF continues to view certain medics more favorably than others when it comes to command positions; however, the opportunity was still available for other corps to compete for *any* command position versus *specific* command positions. Within the LAF, the makeup of Mission Support Groups (MSG) most closely mirrors the MDG. Each of the groups have different AFSCs and functions that must come together to support the Wing mission. The differences between the groups lie in the command selection process at the CSB. In the MSG, any AFSC can command at the group level. At the squadron level, commanders are

typically matched by career field, i.e. civil engineers command Civil Engineer Squadrons, which is very similar to the process defined in the Flight Path. At the group level, the LAF recognizes that each AFSC brings unique skill sets and experiences to command but must possess common leadership characteristics and abilities to accomplish the mission. During the CSB, Wing Commanders review all eligible MSG candidates and select the best candidates for group command regardless of AFSC. All AFSCs are equally competitive. Unfortunately, cultural bias is still a significant obstacle to command for most corps, yet the Flight Path has limited the ability of senior leaders to select the best O-6 for command through Corps Designation.

An alternate measure to use to select the most qualified O-6 would be to identify specific leadership competencies identified in the Joint Medical Executive Skills Development Program. In 1992, a tri-service DoD study group in conjunction with input from over 200 MTF commanders identified 40 competencies comprising the basic skill sets a potential MTF commander should possess before assuming command.<sup>64</sup> These skills can be acquired through military education, graduate education, progressive job experience, and professional certification (Navy and AF).<sup>65</sup> These 40 Executive Skills competencies fall into eight major categories: Military Medical Readiness, General Management, Health Law and Policy, Health Resources Allocation and Management, Ethics in the Health Care Environment, Individual and Organizational Behavior, Clinical Understanding, and Performance Measurement.<sup>66</sup> These competencies are further divided into three proficiency levels: knowledge, application, and expert. Only those skills identified as requiring “expert proficiency” are discussed in this paper.

To succeed as an MTF commander, commanders must exemplify expert competencies in Medical Doctrine, Understanding the Military Mission, Medical Readiness Training, Decision Making, Leadership, Personal and Professional Ethics, Individual Behavior, and

Communication.<sup>67</sup> Those individuals who best manifest the 40 competencies are best prepared to assume MTF command. Specifically identifying these skill sets in medics as a corps neutral process versus five separate DTs with CSB input should level the playing field for MTF commander selection process. Educating and developing these skills from accession is crucial to building future AFMS leaders and most importantly, MTF commanders.

Currently, the AF uses five tools: accessions, assignments, professional military education (PME), training/exercises and deployments, and mentoring to developing aerospace leaders.<sup>68</sup> Two areas in particular are deficient for medical service officers: assignments (command opportunities) and PME. Direct accession programs improved significantly with the change from Military Indoctrinated Medical Service Officer (MIMSO) to Commissioned Officer Training (COT). COT extended training by 2 weeks to improve transition from the civilian to military profession and incorporated more AF-specific leadership training. Assignments continue to foster stovepipes especially under the corps designated command. A small number of officers gain breadth and depth of experience at the Headquarters AF level prior to command yet most do not. Additionally, command tied to corps “strengths” does not fully prepare AFMS leaders for the operational level of command. In “Leadership Development: A Supervisory Responsibility,” Lt Col French advocates “short-term risks” for “the long term benefit of the Air Force.”<sup>69</sup> He further argues “the Air Force cannot continue to produce the strongest possible officer corps by honing each officer’s expertise in only one functional area.”<sup>70</sup> Investment in people and growing strong leaders are just as important if not more important to the Air Force’s future as fielding the next weapon system.<sup>71</sup> The AFMS is not excluded from this assessment.

Although PME is important in officer development, it is the least emphasized tool in the development of AFMS officers. Although the Career Path Guide, or Career Pyramid, reflects

developmental education (DE) at all levels for all corps, in reality, not all corps place an equal emphasis on military DE. Promotion rates of non-DOPMA constrained officers at O-4 and O-5 reflect a severe gap in PME leadership “training” until O-6. (Table 4). MC and DC are simply not required to attend or complete BDE and IDE. Limited in-residence PME opportunities also reflect the blasé attitude. Only at O-6 does DE begin to affect promotions and becomes required for senior leaders (Table 4). On the other hand, NC, BSC, and MSC simply cannot get promoted without DE (Table 4). Medic specific courses, such as the Intermediate Executive Skills Course, frankly do not address the aerospace mission but only focus on AFMS issues. As a leader, it is extremely important to understand the “big” AF in order to develop junior medics and define an AFMS mission consistent with the AF’s. Without rank appropriate DE, medics are left with a poor understanding of the military culture and mission at AF and Joint levels.

Table 4: PME Promotion Rate<sup>72</sup>

Promotion Board	Corps	BDE		IDE		SDE	
		Complete Pct	Did Not Complete Pct	Complete Pct	Did Not Complete Pct	Complete Pct	Did Not Complete Pct
2007	MC	100%	99.60%	100%	96.40%	75.00%	0%
2006		100%	99.30%	100%	99.10%	76.40%	0%
2007	DC	100%	100%	100%	93.30%	92.30%	13.60%
2006		100%	97.40%	100%	100%	88.20%	0%
2007	MSC	93.75%	0%	83.33%	0%	64.29%	0%
2006*		94.94%	0%	80%	0%	54.50%	0%
2007**	NC	81.42%	0%	73.80%	0%	56.10%	0%
2006***		82.61%	0%	67.57%	7.70%	50%	0%
2008	BSC	92.98%	0%	60%	0%	53.13%	0%
2007		92.45%	0%	61.65%	0%	55.17%	0%
2007	Line	94.77%	6.30%	76.81%	10.50%	53.70%	13.90%
2006		94.23%	0%	77.58%	3.60%	53.90%	13.30%

\* MSC Lt Col 2007B

\*\*NC Lt Col 2008

\*\*\*NC Lt Col 2007

NOTE: The Complete column refers to promotion rates of officers that completed Developmental Education. The Did Not Complete column refers to promotion rate of officers that did not complete rank appropriate DE. BDE=Basic Developmental Education; IDE=Intermediate DE; Senior DE

Leadership development is a continuous process that must be infused in the organizational culture of the AFMS as well as the AF. “The Air Force needs leaders with a thorough knowledge of aerospace power in all career fields” to include medical.<sup>73</sup> Aerospace leadership in medics needs to be cultivated from accession to retirement versus as senior leaders. Although the AFMS utilizes courses such as the Intermediate Executive Skills and the MAJCOM Squadron Commander’s Courses to develop new squadron commanders, it does not go far enough to develop leaders prior to command. Leadership cannot be learned in a vacuum restricted to medical-specific issues but must include military leadership training to better support mission requirements. In the joint environment, it is imperative that leaders of all ranks and career fields develop the “Military Medical Readiness Competencies” along with all the other competencies defined in the Joint Medical Executive Skills Program to “improve their qualifications for MTF command or key positions as lead agents and primary staff.”<sup>74</sup>

The AFMS needs to return to the basics to build strong, competent medical leaders from accession rather than thrusting ill-prepared officers into leadership positions by virtue of rank and AFSC. It is unfair to the organization and the individual who is forced to sink or swim in command positions without being given the requisite tools to succeed. According to the 2005 AF Climate Survey, medical leadership was ranked among the lowest in organization types in outcome index (performance perceptions, organizational commitment, and satisfaction) and trust in senior leader.<sup>75</sup> To improve future perceptions of medical commanders and senior leaders, it is important to return to the basics of leadership. Part of the return to leadership basics requires: 1) a complete separation of functional advisor positions and squadron commander positions, 2) return to corps-neutral group command positions, and 3) reinvigorate DE for medics.

## RECOMMENDATIONS

The current AFMS Flight Path has not fully satisfied the 2004 CSAF guidance for Promotions, Redefine Medical Groups, and Command Opportunities. Transformation requires adaptation and openness to new problem-solving methodology and solutions. The AFMS Flight Path is not a transformational process but one that is mired in stovepipes and corps parochialism. To truly achieve a balance of the demands placed on the military professional, the AFMS must realign its priorities. The AF and subsequently the AFMS readiness mission must supersede the peacetime healthcare mission. The formula for success rests on the development of an AFMS leadership which is not dictated by corps traits and attributes. The following recommendations are based on leadership-driven aspects to create a formidable AFMS prepared for the joint fight.

### ***Realign non-DOPMA Promotion Opportunities***

The AF/SG and the Secretary of the Air Force needs to reevaluate the 100% promotion opportunity levels established at the O-4 and O-5 promotion “boards” for non-DOPMA constrained officers and explore alternative incentives to retain physicians and dentists. The original purpose of excluding “professionals” (physicians and dentists) from the DOPMA promotion system was to provide equal promotion opportunity separate from the line. This concern simply does not exist as professionals are only competing against professionals in similar career fields. Instead, the near 100% promotion rate creates a rank heavy environment of physicians and dentists particularly at the O-5 level. Because of rank, AFPC begins to place the professionals in roles that place increasing demand on their time and remove them from their primary duties i.e. supervisory positions, Flight Commander, functional advisors, Deputy Group Commander, staff jobs, etc.... A leveling of rank at the field grade officer level would better mitigate corps rivalry than the current guidance established under the Flight Path.

A potential negative consequence would be an increased desire to move away from traditional clinic positions (primary duties) into these career broadening-type opportunities in order to achieve the next rank. The establishment of three separate career tracks (Clinical, Research and Development, and Command) as avenues to attain O-6 has not done much to keep professionals in traditional clinic roles. In addition, the high operations tempo associated with OEF and OIF coupled with poor retention rates have left MTFs with manning far below optimal operating conditions. Frankly, the MTF needs providers to stay in the clinic. Instead, the AFMS needs to provide incentives for keeping providers in AF clinics much as the AF has resorted to “extended service bonuses” for pilots and critically manned career fields. AFMS should be no different. This “bonus” should be separate from the Title 37 specialty pay authorizations for medics. Professionals could earn pay for their professional expertise and would remain on the “Clinical track” throughout their career. Pay them for their professional expertise yet promote them for their military expertise. Fully realizing this initiative requires cross-service coordination with the Army and Navy so as not to bias one service over the other for recruiting and retention purposes. Unless the AF is willing to accept rank inversion as a norm in the MTFs to keep providers as providers, then the promotion system should revert to the original purpose of rewarding those individuals with the demonstrated potential to serve in the next higher rank.

### ***Reevaluate Medic Career Profiles under DOPMA***

Although managing three separate and distinct medic corps under DOPMA is complicated, the AFMS needs to seriously evaluate current corps management practices to achieve parity within the medical community. The “ideal officer career profile” envisioned under DOPMA does not exist for these corps. The BSC poses a unique challenge with managing

17 different career fields all with different AFSC-specific certification requirements, ranging from a simple course-completion certificate to doctorate level degrees. In particular, normal attrition rates assumed under the DOPMA system have contributed to the variability in promotion opportunities and timing between corps. It is time for the AF to reevaluate these career fields as promotions to the O-5 and O-6 level are becoming fewer and farther apart for the BSC while promotion boards for MSCs are experiencing the opposite effect. The NC is showing positive progress in this area.

As indicated, promotions are the “carrot” for good performance and leadership. As BSC and NC officers begin to fall farther behind their line and MSC peers, quality medics in these corps may become frustrated and leave the AF. The NC has seen a dramatic shift away from clinical nursing positions for field grade officers vying for promotions. Clinical nursing positions are being contracted out and converted to civilian positions to fill the gap within the MTF. DoD is already struggling to recruit nurses from the civilian community which is also experiencing a shortage nationwide. Future generations of leaders within the NC and BSC are becoming older and older as the younger generations, faced with bleak promotion opportunities, opt to leave at the end of their service commitment. To some extent, the exodus has already started for the MSCs who are experiencing the opposite effect with a shortened promotion cycle. The MSC are beginning to see younger and less experienced officers in senior leader positions.

The answer to recapitalizing the AFMS DOPMA officers lies beyond the scope of this paper but requires a serious reevaluation for how the AFMS manages these corps members under DOPMA. The Flight Path has not truly addressed the heart of the promotion inequity that exists among the DOPMA corps and was not intended to address this aspect of the promotion opportunity. Whether in the short term or long term, the AF will need examine the long term

implications of the current track for promotions for AFMS officers under DOPMA.

Perhaps eliminating DOPMA altogether for medics is one avenue to explore to solve joint medical retention and promotion issues. Again, cross-service coordination is paramount to maintain consistency in the Defense Department. The Office of the Secretary of Defense would have to be willing and able to build a strong case to get Congressional legislation and the associated funds to support such a transformational shift in medic promotions.

### ***Separate Command and Functional Advisor Positions***

The AFMS should eliminate the dual squadron command-functional advisor positions at the MTF with one exception, the Dental Squadron Commander/SGD. By its very nature, the Dental Squadron (DS) is the only homogenous entity within the MDG. The duties of the DS Commander and the SGD almost completely overlap. By separating out all other dual positions, DTs could better select members for squadron command and the functional advisor positions. Squadron commanders would be able to focus on leadership, and the functional advisor would be able to focus on management. Separating functional advisor position from command would serve three functions: 1) “balance corps leadership” throughout the MTF through the advisors versus at the squadron commander level, 2) hone the functional advisor role to optimizing healthcare delivery, and 3) create additional leadership opportunities within the MTF.

Commanders, in their very nature, are fully capable of providing career advice and mentoring junior medics. Currently, functional advisor and squadron commanders are performing the same function. At present there are over 100 dual functioning squadron commanders. Excluding the Dental commanders/SGD leaves the AFMS with approximately 70 dual-hatted commanders. MTFs with capable senior corps leaders operating in different positions could pick up the “dual-hat” position i.e. Flight Commander. Some facilities may not

be capable of “dual-hatting” from within whether from manpower constraints (i.e. no senior corps officer available to fill position) or functional advisor position requires full-time position. Most often, SGN and SGH positions tend to require a full-time equivalent position secondary to the additional civilian accreditation requirements associated with these positions. There are only three bases with dual-hatted (one squadron and two deputy commanders) SGN positions and no SGH dual-hatted positions. In these cases, a separate manpower position should be authorized. Although eliminating “dual-hat” positions could potentially increase manpower authorizations, realigning medical squadrons at the clinic level could offset the additional requirements.

### ***Consolidate Medical Squadrons at Small MTFs***

The AFMS should minimize the number of squadrons at the clinic and at certain clinic-plus MTFs. Instead of letting force development drive the standardized four squadron model under OMG, small clinics could easily organize into a two to three squadron MDG. AFI 38-101 cautions “Do not fragment a capability into multiple squadrons when a single squadron provides a parent wing or group commander the best approach in terms of a coordinated, focused capability under single direction.”<sup>76</sup> Consolidation would simplify organizational structure in small facilities without sacrificing command and control.

In the previous recommendation, a balanced leadership team would exist under distinct core functional advisor positions; therefore, there is less of a need to create a balanced leadership team at the squadron level. Although this move would decrease the overall number of squadron command opportunities, more leadership opportunities would exist under functional advisors.

Under previous OMG provisions and AFI 38-101, smaller squadrons could be rolled up along “product lines” into a larger MDOS, an ADOS, or an AMDS without compromising the unit’s mission. Bases would need to be evaluated on a specific set criteria established at HHQ

level to minimize personality-driven input at individual wings. Consolidating squadrons would 1) maintain adequate command and control, 2) decrease the manpower requirement at the command level, and 3) free up additional manpower requirements to support separating squadron command and functional advisor positions.

### ***Standardize Force Development Tools across AFMS Corps***

Force Development tools standardization across corps is critical to developing AFMS aerospace leaders. An important piece of developing medical leaders is establishing and fostering a formal leadership education program. PME is one tool to build professional military leaders. Although all medic career path pyramids identify BDE, IDE, and SDE as building blocks to career progression, the promotion system does not; therefore, PME is not emphasized equally across the corps. Although the AFMS can ill-afford to lose clinicians from the MTF, it is crucial to have some type of PME program available for professional medics to completely gain an understanding and appreciation of aerospace operations.

The AFMS should request Air Education and Training Command (AETC) to develop abbreviated medic PME programs (BDE and IDE equivalent) with special emphasis on building the 40 Joint Medical Executive Skills competencies and a broader understanding of the air, space, and cyberspace mission. Current medic development programs such as the Intermediate Executive Skills course focus only on medical issues and not on airpower or joint operations.

Formalized medic-specific PME programs emphasizing air and joint operations and leadership competencies would go a long way to bridging the gap in “military medical readiness competencies” as defined in the Joint Medical Executive Skills program and create a common operating picture between the line and medics. Abbreviated medic-specific PME courses would serve three purposes: 1) keep clinicians in the MTF without sacrificing a significant portion of

time to training, 2) build a much-needed knowledge base of air and joint ops for AFMS medics, and 3) establish a leadership education system from accession to retirement for all medics.

### ***Eliminate Corps Designation for Command***

At the wing and group, the AFMS should eliminate corps-designated command. However, the AFMS should retain the current squadron commander designation process until a well-defined process to fill the functional advisor positions is defined and dual-hatted positions are eliminated. At the wing and group level, the commander's AFSC or corps should be relegated to leadership qualities. The change to a corps-neutral selection process could occur immediately without disrupting the cross-corps leadership balance established at the squadron and functional advisor positions. Furthermore, a second command opportunity at the hospital (large group) and medical center (MDW) level would open up to all corps versus only medical corps candidates. This would continue to foster senior leadership development cross-corps. By adopting a "corps-neutral" selection process at these levels, the AFMS could concentrate more on selecting the best qualified leader to execute the mission at the base level.

Although AFMS risks returning to the previous system under OMG with a cross-the-board corps-neutral selection process for commanders and a loss of group commands for historically underrepresented corps such as BSCs, it is imperative the Wing Commander retain the flexibility to choose commanders that best exemplify the leadership traits and abilities necessary to advance the LAF mission given the current operating environment. Expertise in skill sets should remain at the three-letter positions and not at the command level.

At the operational and strategic levels, the AFMS must continue to support line commanders in selecting the best candidates, not from a subset of candidates, but from the AFMS as a whole. By retaining the current designated squadron commander positions in the

short term would preserve the ability of corps other than MC and MSC to prove their mettle. The goal is to attain positive feedback regarding individuals versus corps that would up-channel and create a corps-neutral leadership environment for future group and wing commander selection boards. Military medicine's tie to line leadership is an AF service-unique relationship. It is crucial that the AFMS preserve it at all costs.

### ***Revamp the Command Screening Board Process***

To support a "corps-neutral" command process, the CSB needs to be revamped. Current DTs have a vested interest in the candidates selected to compete for command opportunities. To break the provincial attitudes that permeate the AFMS, it is essential to create a medical CSB tailored to line needs. The best way to achieve a balance among corps would be to establish a criterion based approach to command selection led by a line General Officer. DTs would continue to provide a baseline set of candidates with competencies similar to those outlined in the Joint Medical Executive Skills. This CSB process would be similar to a DOPMA medic promotion board where line officers preside over the board and similarly provide input during the selection process. Instead of a forced corps development process under the Flight Path, this model would promote a healthy "competitive" environment where the best leaders would attain command. In essence, the needs of the AF would dictate over the individual corps.

This same process could be applied at future squadron commander CSBs. This move would only be possible if the AFMS creates a corps-balanced leadership team through functional advisors versus the current approach with corps-designated squadron commands. Secondly, the AFMS would also need to adopt a common force development process for medics. At the operational level, it is important to continue to develop the basic leadership skills and joint medical competencies requisite for higher command and senior leadership positions. Under

different circumstances where medics would be considered medics regardless of corps and as the AFMS begins to develop sound leaders across all corps, squadron commanders should move to corps-neutral positions. Considering differences in promotion and retention rates among the five medic corps at this time, squadron command should remain “designated” for two reasons 1) preserve corps leadership balance established under the Flight Path and 2) provide a relatively equal-opportunity for all medic corps to achieve command at the squadron level.

## **CONCLUSION**

The AFMS Flight Path continues to tout the viability of the OMG healthcare model established in 1993 as the optimal MTF structure. Not only does the organizational structure easily transition from peacetime to expeditionary operations but also addresses the dual responsibility of military medicine’s readiness and peacetime accreditation standards. However, the AFMS Flight Path has done little to promote leadership within the organization. By adopting a “corps-neutral” approach to leadership and promoting a life-long cross-functional leadership education program as outlined above, the AFMS can truly transform into an organization best suited to meet LAF mission demands. As former CEO of General Electric Jack Welch once said, “Before you are a leader, success is all about growing yourself. When you become a leader, success is all about growing others.”<sup>77</sup> The AFMS Flight Path requires at least one more revision to build premier expeditionary leaders within the military medical community.

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